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APPLICATION NO.	FILING DATE	FIRST NAMED INVENTOR	ATTORNEY DOCKET NO.	CONFIRMATION NO.
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EXAMINER	
DESAI, RITA J	
ART UNIT	**PAPER NUMBER**
1625	

SHORTENED STATUTORY PERIOD OF RESPONSE	MAIL DATE	DELIVERY MODE
3 MONTHS	12/22/2006	PAPER

Please find below and/or attached an Office communication concerning this application or proceeding.

If NO period for reply is specified above, the maximum statutory period will apply and will expire 6 MONTHS from the mailing date of this communication.

Office Action Summary	Application No.	Applicant(s)	
	10/781,340	CUTSHALL ET AL.	
	Examiner	Art Unit	
	Rita J. Desai	1625	

-- The MAILING DATE of this communication appears on the cover sheet with the correspondence address --

Period for Reply

A SHORTENED STATUTORY PERIOD FOR REPLY IS SET TO EXPIRE 3 MONTH(S) OR THIRTY (30) DAYS, WHICHEVER IS LONGER, FROM THE MAILING DATE OF THIS COMMUNICATION.

- Extensions of time may be available under the provisions of 37 CFR 1.136(a). In no event, however, may a reply be timely filed after SIX (6) MONTHS from the mailing date of this communication.
- If NO period for reply is specified above, the maximum statutory period will apply and will expire SIX (6) MONTHS from the mailing date of this communication.
- Failure to reply within the set or extended period for reply will, by statute, cause the application to become ABANDONED (35 U.S.C. § 133). Any reply received by the Office later than three months after the mailing date of this communication, even if timely filed, may reduce any earned patent term adjustment. See 37 CFR 1.704(b).

Status

1)☒ Responsive to communication(s) filed on *01 December 2006*.

2a)☐ This action is **FINAL**. 2b)☒ This action is non-final.

3)☐ Since this application is in condition for allowance except for formal matters, prosecution as to the merits is closed in accordance with the practice under *Ex parte Quayle*, 1935 C.D. 11, 453 O.G. 213.

Disposition of Claims

4)☒ Claim(s) *31-42* is/are pending in the application.

4a) Of the above claim(s) _____ is/are withdrawn from consideration.

5)☐ Claim(s) _____ is/are allowed.

6)☒ Claim(s) *31-42* is/are rejected.

7)☐ Claim(s) _____ is/are objected to.

8)☐ Claim(s) _____ are subject to restriction and/or election requirement.

Application Papers

9)☐ The specification is objected to by the Examiner.

10)☐ The drawing(s) filed on _____ is/are: a)☐ accepted or b)☐ objected to by the Examiner.

Applicant may not request that any objection to the drawing(s) be held in abeyance. See 37 CFR 1.85(a).

Replacement drawing sheet(s) including the correction is required if the drawing(s) is objected to. See 37 CFR 1.121(d).

11)☐ The oath or declaration is objected to by the Examiner. Note the attached Office Action or form PTO-152.

Priority under 35 U.S.C. § 119

12)☐ Acknowledgment is made of a claim for foreign priority under 35 U.S.C. § 119(a)-(d) or (f).

a)☐ All b)☐ Some * c)☐ None of:

1.☐ Certified copies of the priority documents have been received.

2.☐ Certified copies of the priority documents have been received in Application No. _____.

3.☐ Copies of the certified copies of the priority documents have been received in this National Stage application from the International Bureau (PCT Rule 17.2(a)).

* See the attached detailed Office action for a list of the certified copies not received.

Attachment(s)

1) ☐ Notice of References Cited (PTO-892)
2) ☐ Notice of Draftsperson's Patent Drawing Review (PTO-948)
3) ☐ Information Disclosure Statement(s) (PTO/SB/08) Paper No(s)/Mail Date _____.
4) ☐ Interview Summary (PTO-413) Paper No(s)/Mail Date. _____.
5) ☐ Notice of Informal Patent Application
6) ☐ Other: _____.

DETAILED ACTION

The finality of the action mailed 9/6/2006 has been withdrawn due to New rejections.

Claims pending 31-42.

The rejection under 35 U.S.C. 102 over Danilenko V et al has been withdrawn.

The rejection of the claims under 35 U.S.C. 112 first paragraph scope of enablement still stands.

The examiner is repeating the rejection here.

) The breadth of the claims: The instant claims encompass many compounds from an aromatic carbocyclic moiety to an aromatic carbocyclic moiety having many large electron withdrawing and bulky groups substituted on it to a moiety having many heterocyclic rings. These compounds cover a very wide range of compounds. With R1 being R5 or R5-(C1-C6 heteroalkylene)

2) The nature of the invention: The invention is a (highly) substituted compound that is useful to treat and inhibiting various receptors.

3) The state of the prior art: Applicants own background information on the Chemokine receptors and G-proteins indicate that they are of several types and are found in all the various cells and tissues and are of a variety of types. G-protein

-coupled 7TM receptor would still be another type. The inhibiting of the various cellular events or treat the various diseases by these receptors is not an absolute predictability.

The state of the prior art is that it involves screening in vitro and invivo to determine which

compounds exhibit the desired pharmacological activities. There is no absolute predictability and no established correlation between in vitro activity and the treatment of various diseases and also the IC 50 values, as the in vitro data is not a reliable predictor of success even in view of the seemingly high level of skill in the art. The existence of these obstacles establishes that the contemporary knowledge in the art would prevent one of ordinary skill in the art from accepting any therapeutic regimen on its face.

Please see article by James Cumming et al Expression and Function of Chemokine Receptors CXCR1 and CXCR2 in Sepsis. The article clearly illustrates the complication of selecting therapeutic targets to reduce inflammation. The study clearly shows the specificity of the receptor and the disease.

4) The level of one of ordinary skill: The ordinary artisan is highly skilled.

5) The level of predictability in the art: It is noted that the pharmaceutical art is unpredictable , requiring each embodiment to be individually assessed for physiological activity. In re Fisher, 427 F. 2d 833, 166 USPQ 18(CCPA 1970) indicates that the more unpredictable an area is, the more specific enablement is necessary in order to satisfy the statue. The level of unpredictability is in the art is very high couples with the fact that applicants compounds of formula I has a very wide scope with all the various R1 and R4 groups. For e.g. the compounds which differ by a methyl group also show different properties, for e.g. theophylline and caffeine. One of them is a bronchodilator and they differ only by a methyl group.

6) The amount of direction provided by the inventor: The inventor provides very little direction in the instant specification. There are no examples with the R being hetero cyclic

groups and also there is no data provided to show that these compounds do indeed treat various diseases. The only data provided is of 9 compounds that have an IC50 as given in **table 6** page 67, 68 of the specifications. Even this data is not consistent. The first compound does not show any CCR5 activity.! And the second last does not have any NPY1 and somat activity.!

7) The existence of working examples: The instant specification has only 9 examples with a few assays.

8) The quantity of experimentation needed to make or use the invention based on the content of the disclosure: Since there are no working examples, and since the state of the art clearly indicates that diseases are related to very specific sub type receptors coupled with the fact that drugs have very limited predictability , the amount of experimentation is very high and burdensome and it not clear who the patient in need there of is who would require the antagonizing or inhibiting treatment since the scope of the claim is drawn to any chemokine receptor, inhibition of any chemokine mediated cellular "event" , without any indication of which patient population.

Taking the above eight factors into consideration, it is not seen where the instant specification enables the ordinary artisan to make and/or use the instantly claimed invention.

A small scope of compounds according to the invention have been made. The assay test is noted. While these screening test in an enzyme assay provides data in certain inhibiting activity, it does not provide sufficient operational guidance in an "individual" in patho-physiological environment.

Genetech Inc Vs Nova Nordisk 42 USPQ 2d 1001.

"A patent is not a hunting license. It is not a reward for search but compensation for its successful conclusion and patent protection is granted in return for an enabling disclosure of an invention , not for vague intimations of general ideas that may or may not be workable."

In re Fisher, 427 F. 2d 833, 166 USPQ 18(CCPA 1970) indicates that the more unpredictable an area is, the more specific enablement is necessary in order to satisfy the statue.

"in cases involving unpredictable factors, such as most chemical reactions and physiological activity, scope of enablement varies inversely with degree of unpredictability of factors involved"

Applicants argue that they have some examples showing the different activity and events . for example 21 provide s example of the process that is mediated by a G-protein-coupled 7TM receptor.

The table 3-5 do have data of IL-8 and GRO- α but it is not clear how the compounds could in fact treat ,

Modulate cellular "events", treat all the various disorders such as IBD, psoriasis, AIDS, cancer, artheroschlerosis, refusion injury.

Or antagonizing chemokine receptors, or

inhibiting a chemokine mediated cellular "event" or

inhibiting IL8, GRO-alpha driven neutrophil chemotaxis or

treat a disorder selected from IBD, psoriasis, AIDS, cancer, atherosclerosis, reperfusion injury or

inhibiting a G-protein –coupled , 7TM receptor or

modulate binding of Peptide YY to a NPY receptor or

modulated the binding of a somatostatin to a somatostatin cell receptor or

treat , through a therapeutically or prophalactically acceptable manner an inflammatory "event".

Additional comments on the above rejection.

Applicants claims read therapeutically effective amount and a patient in need thereof.

This implies it is for treating a certain condition.

The table 3-5 do have data of IL-8 and GRO- α but it is not clear how the compounds could in fact treat ,

Modulate cellular "events", treat all the various disorders such as IBD, psoriasis, AIDS, cancer, atherosclerosis, refusion injury.

The state of the art tells us that drugs do not have an umbrella efficacy of treating various disorders from AIDS to cancer , IBD, refusion injury. The predictability in the art is also very little and hence applicants need to show and provide more.

Applicants argue that their compounds treat conditions involving inflammation caused by neutrophil chemotaxis mediated via CXR1 and CXR2 receptors.

There is no guidance regarding which diseases are mediated by the chemokine.

Inflammation can be mediated by numerous receptors and activity. Some are given here below.

The specification does not enable any physician skilled in the art of medicine, to use the invention commensurate in scope with these claims. Firstly, for a compound or genus to be effective against inflammation generally is contrary to medical science. Inflammation is a

process that can take place in virtually any part of the body. There is a vast range of forms that it can take, causes for the problem, and biochemical pathways that mediate the inflammatory reaction. There is no common mechanism by which all, or even most, inflammations arise. Mediators include bradykinin, serotonin, C3a, C5a, histamine, leukotrienes, cytokines, and many, many others. Accordingly, treatments for inflammation are normally tailored to the particular type of inflammation present, as there is no, and there can be no "magic bullet" against inflammation generally.

Inflammation is the reaction of vascularized tissue to local injury; it is the name given to the stereotyped ways tissues respond to noxious stimuli. These occur in two fundamentally different types. Acute inflammation is the response to recent or continuing injury. The principal features are dilatation and leaking of vessels, and recruitment of circulating neutrophils. Chronic inflammation or "late-phase inflammation" is a response to prolonged problems, orchestrated by T-helper lymphocytes. It may feature recruitment and activation of T- and B-lymphocytes, macrophages, eosinophils, and/or fibroblasts. The hallmark of chronic inflammation is infiltration of tissue with mononuclear inflammatory cells. Granulomas are seen in certain chronic inflammation situations. They are clusters of macrophages that have stuck tightly together, typically to wall something off. Granulomas can form with foreign bodies such as aspirated food, toxocara, silicone injections, and splinters.

Otitis media is an inflammation of the lining of the middle ear and is commonly caused by Streptococcus pneumoniae and Haemophilus influenzae. Cystitis is an inflammation of the bladder, usually caused by bacteria. Blepharitis is a chronic inflammation of the eyelids that is caused by a staphylococcus. Dacryocystitis is inflammation of the tear sac, and usually occurs

after a long-term obstruction of the nasolacrimal duct and is caused by staphylococci or streptococci. Preseptal cellulitis is inflammation of the tissues around the eye, and Orbital cellulitis is an inflammatory process involving the layer of tissue that separates the eye itself from the eyelid. These life-threatening infections usually arise from staphylococcus. Hence, these types of inflammations are treated with antibiotics.

Cholecystitis is gallbladder inflammation usually caused by a gallstone that cannot pass through the cystic duct. In those cases, it normally cannot be treated by pharmaceuticals but instead the gallbladder is removed. Cholecystitis without the formation of gallstones, called acalculous cholecystitis, is caused by bacteria such as Salmonella, Staphylococcus, Streptococcus (as part of scarlet fever), and leptospirosis, and thus may be treatable by treating the underlying infectious agent. Acute inflammation of the gall bladder can also arise from typhoid; treatment is with antibiotics.

In gout, joint inflammation is caused by the formation of monosodium urate monohydrate (MSU) crystals within the joint space. Acute attacks of gout are treated with colchicine (to inhibit of MSU-induced chemotactic factor release by PMNs) and after the acute phase with allopurinol to control the blood levels of uric acid. Pseudogout, sometimes referred to as calcium pyrophosphate disease (CPPD), is inflammation caused by calcium pyrophosphate (CPP) crystals. It is treated with nonsteroidal anti-inflammatory drugs, corticosteroids, and colchicine.

Sinusitis is the inflammation of the mucosal lining of one or more sinuses. It commonly accompanies upper respiratory viral infections and in most cases requires no treatment.

Pharyngitis (tonsillitis) is an inflammatory illness of the mucous membranes and underlying structures of the throat (nasopharynx, uvula, and soft palate). The illness can be

caused by bacteria, viruses, mycoplasmas, fungi, and parasites, and uncertain causes, especially Streptococcus pyogenes, adenoviruses, influenza viruses, parainfluenza viruses, Epstein-Barr virus, enteroviruses, and Mycoplasma pneumoniae. Similarly, Osteomyelitis is the inflammation of bones, generally caused by bacteria (most commonly Staphylococcus Aureus). Fungi or viruses can cause the disease. Dacryoadenitis, an inflammation of the tear gland, can arise from infectious mononucleosis, mumps, gonorrhea, or influenza. Conjunctivitis (pink eye) is inflammation of the conjunctiva and can be caused by many microorganisms, including staphylococci, Haemophilus influenzae, streptococci, gonococci, and viruses such as adenoviruses. Treatment in all of these cases, when possible, is thus to the underlying infectious agent.

Rheumatoid arthritis is an inflammatory bone disease causing destruction of articular cartilage, in which macrophages accumulate in the rheumatoid synovial membrane. Mediators are cytokines, including IL-18 and IL-18, and IFN- .

Pneumonia is an inflammation of the lungs that can be caused by viruses (such as respiratory syncytial, parainfluenza, and influenza), bacteria, fungi, mycoplasmas, rickettsias (especially Q fever), Chlamydia, or parasites. It can also occur as a hypersensitivity, or allergic response, to agents such as mold, humidifiers, and animal excreta, and in such a case would be treated with anti-allergic agents.

Other inflammations in the respiratory system include CF, adult respiratory distress syndrome, asthma, and bronchitis.

Myocarditis is an inflammation of the muscular middle layer of the heart (myocardium) Viruses, bacteria, and noninfectious diseases can cause it. Treatment is primarily supportive e.g.

drugs may be used to improve the heart's ability to contract and to remove extra fluids from the body. Unless the underlying infectious agent itself is treatable, this inflammation is not itself treated.

Glossitis is inflammation of the tongue. Local causes of glossitis include bacterial or viral infection, mechanical irritation or injury from burns, rough edges of teeth or dental and oral appliances, or other trauma; exposure to irritants (tobacco, alcohol, hot foods, or spices), and sensitization (to e.g. toothpaste, mouthwash, breath fresheners, dyes in candy, plastic in dentures or retainers) anemia and other B vitamin deficiencies, erythema multiform, pemphigus vulgaris, syphilis, and other disorders. It can be inherited. Corticosteroids such as prednisone may be given to reduce the inflammation. Antibiotics, antifungal medications, or other antimicrobials may be prescribed if the cause of glossitis is an infection. Anemia and nutritional deficiencies must be treated, often by dietary changes or other supplements.

Meningitis is an inflammation of the outer covering of the brain and spinal cord. Virtually any known infectious agent can cause it. Thus, if it were caused by Haemophilus influenzae or Neisseria meningitis, the antibiotic derivative rifampin would be used.

Encephalitis is an inflammation of the brain itself. It is most often caused by a group of arboviruses. Treatment of encephalitis is largely supportive because no specific antiviral agents, except for that which works against herpes simplex virus, are available for therapy.

Hepatitis is an inflammation of the liver, usually caused by viral invasion, notably hepatitis A, B and C, but sometimes Epstein-Barr virus; herpes simplex viruses; measles, mumps, and chicken pox viruses; and cytomegaloviruses. Treatment, when possible, is with

antivirals. Inflammation of the liver also takes the form of alcoholic hepatitis. Lupoid hepatitis is an autoimmune disorder.

Hemorrhoids are an enlarged or varicose condition of the hemorrhoidal veins and tissues around the anus, either internal or external. Anything that obstructs the free circulation of the blood in the portal system will give rise to hemorrhoids. Constipation, straining at stool, diarrhea, dysentery, rough toilet paper, uncleanness, pelvic tumors, displacement of the uterus and pregnancy are among the most common causes.

There is a series of inflammatory problems directly connected to neutrophil-endothelial cell adhesion (NECA). These include frostbite injury, bacterial meningitis, acute airway inflammation, allograft rejection, hemorrhagic shock, septic shock, ischemia, and reperfusion injuries.

Urethritis is an inflammation of the duct that leads from the bladder to the exterior of the body. It is often due to fecal contamination or irritation due to physical or chemical substances (e.g. introduction of foreign bodies into the urethra, bubble bath, or soap) or gonorrhea. Treatment may simply involve the withdrawal of the offending chemical agent, or the administration of antibiotics, when Neisseria gonorrhoeae is involved.

Inflammation can arise from the eruption of teeth in a child (teething).

Inflammation of the nails can arise from chronic paronychia, fungus (especially Candida albicans), trauma, impaired circulation, and dermatitis.

Bright's disease (or glomerulonephritis) is inflammation of the glomeruli and the nephrons, the structures in the kidney that produce urine. It usually results from an infection,

such as a streptococcal infection, that occurs somewhere else in the body. There is no real treatment beyond relief of the symptoms.

Thyroiditis is an inflammation of the thyroid gland, and takes three forms. Hashimoto's Thyroiditis (chronic lymphocytic thyroiditis) is the most common type of thyroiditis. It is an autoimmune disorder, and treatment is to start thyroid hormone replacement. For De Quervain's Thyroiditis (subacute or granulomatous thyroiditis), treatment is usually bed rest and aspirin to reduce inflammation. Occasionally cortisone and thyroid hormone may be used. Silent Thyroiditis usually arises following pregnancy. Treatment is usually bed rest with beta-blockers.

Regional enteritis (Crohn's disease or ileitis) is an autoimmune disorder, which is associated with the presence of Mycobacterium paratuberculosis. It can affect any part of the gastrointestinal tract but most commonly affects the ileum. The inflammation is controlled primarily by regulation of diet, antibiotics if abscesses and fistulas are present, sometimes Prednisone and other corticosteroids, and surgery.

Stomatitis, inflammation of the mouth, and mucositis, inflammation of the mucosa can arise from sources as diverse as Candida albicans, dentures, chemotherapy, and radiation therapy to the head, neck or mouth ("Radiation mucositis"). It may be secondary to infection, trauma, systemic diseases or autoimmune mechanisms. These come in many forms, such as aphthous ulcers, Acute Necrotizing Ulcerative Gingivitis i.e. "trench mouth", and Lichen Planus. Herpetiform ulcers treatment has ranged from antibiotics, immunosuppressants and yogurt, to Lactobacillus capsules, tetracycline and systemic steroids. Palliative measures include topical anesthetics, Vitamin E, analgesics, and coating agents. Antiviral agents may be used if viral origin is established.

Pancreatitis is inflammation of the pancreas and can arise from abdominal trauma, or the formation of gallstones that obstruct the common bile duct. It can be associated with excessive ingestion of alcohol; with disorders such as cystic fibrosis or Reye's syndrome; or with scorpion stings. Infectious causes include mycoplasmas, Epstein-Barr viruses, Coxsackie viruses, leptospirosis, hepatitis viruses, mumps, congenital German measles, Ascaris worms, and syphilis. The inflammation per se is generally not treatable. Treatment is usually supportive and consists of the management of pain and intravenous feeding.

Neuroretinitis is inflammation of the retina and optic nerve of the eye ("optic neuritis"). It is often idiopathic. It frequently arises secondary to some kind of infection, such as Hepatitis B, HSV, EBV, influenza A, mumps, Coxsackie B, TB, salmonella, Lyme disease, syphilis, leptospirosis, Histoplasmosis, Toxoplasmosis, toxocara, Sarcoidosis, and cat-scratch disease. Treatment is thus to the underlying cause. For example, diffuse unilateral subacute neuroretinitis (DUSN) arises from nematodes deep in the retina or in the subretinal space. Anthelminthic treatment is then used. When the origin is Toxoplasmosis, then anti-Toxoplasma medications such as Pyrimethamine.

Other eye inflammations include scleritis and episcleritis, inflammation of tissues on the sclera; choroiditis, inflammation of the middle coat (choroid) of the eyeball, and uveitis, which is inflammation of the parts of the eyes that make up the iris.

Gastritis is inflammation to the stomach lining. Atrophic gastritis is characterized by the loss of the stomach cells that are responsible for manufacturing acid, pepsin, and intrinsic factor. This condition occurs in older people or those suffering from Helicobacter pylori. Erosive (hemorrhagic) gastritis occurs when shallow ulcers or sores develop on the upper layer of the

stomach lining, usually because of the excessive ingestion of a stomach irritant such as aspirin or alcohol.

There can also be mentioned appendicitis, which can occur when a hard piece of stool blocks the opening of the appendix, causing swelling and inflammation.

The great majority of skin problems involve some type of inflammation, such as response to physical injury (e.g. sunburn, ticks, abrasion, or a bee string), acute allergic contact dermatitis (such as poison ivy), and infections (such as boils and cold sores). Ingrown hairs, or pili incarnati, can cause acute pustular reactions. Cancerous lesions of the skin frequently show some degree of inflammatory response. The inflammation of acne is caused by leakage of sebum and keratin debris outside the distended pilosebaceous duct. The bacillus Propionibacterium acnes, which populate the lesions, may also contribute indirectly to this inflammation by metabolizing the sebum to produce irritant fatty acids. Inflammation in skin problems is usually the result of the release of chemical mediators in the skin, notably histamine, peptides (kinins) and fatty acids (prostaglandins and leukotrienes), that are formed enzymatically in response to e.g. injury. Medications designed to counteract inflammation in the skin may or may not antagonize the effects of the particular type of mediator involved, if that is known. The inflammation can take many different forms, including redness, (from dilation of blood vessels); heat, (from increased blood flow); swelling (from leakage of fluid from the small blood vessels); whealing reactions (hives, nettle rash, urticaria) in which vascular changes predominate, and pain or itching. Blisters (from enzymes released from inflammatory cells, resident cells of the skin, or blood plasma components) can cause the breakdown of proteins responsible for the structural integrity of the skin, leading to serious inflammatory disorders such as pemphigus. In addition, the

affected skin may feel indurated (hardened) because of the deposition of the coagulation protein fibrin and the infiltration by inflammatory blood cells (lymphocytes, histiocytes, and polymorphonuclear leukocytes).

Prostatitis, inflammation of the prostate, comes in several different forms, including those of bacterial origins, and those, which are not, including chronic abacterial prostatitis and asymptomatic inflammatory prostatitis. Certain types of anti-inflammatory agents, such as non-steroidal anti-inflammatory medications (Ibuprofen and naproxen) along with muscle relaxants can be used in the non-bacterial cases.

The above list is by no means complete, but demonstrates the extraordinary breadth of causes, mechanisms, and treatment (or lack thereof) for inflammation. It establishes that it is not reasonable to any agent to be able to treat inflammation generally and applicats have not provided any direction as to which inflammation "events" are included.

Cancer is another example . The art is highly unpredictable. A drug effective in treating brest cancer would be ineffective in treating lung cancer for example.

Thus with such a laundry list of "events" possible applicants need to provide more.

New rejections

Claim Rejections - 35 USC § 112

The following is a quotation of the second paragraph of 35 U.S.C. 112:

> The specification shall conclude with one or more claims particularly pointing out and distinctly claiming the subject matter which the applicant regards as his invention.

Claim 31-42 are rejected under 35 U.S.C. 112, second paragraph, as being indefinite for failing to particularly point out and distinctly claim the subject matter which applicant regards as the invention.

The claim recites R1 is R5-(C1-C6 heteroalkylene)- .

If the R5 is a H and linked via a C1 alkylene it is unclear how it would have a hetero atom too.

Clarification and correction is required. The table indicates R1 to be CH3- in example 11 and also in the last compound on page 53.

Conclusion

Claims 31-42 still stand rejected.

Any inquiry concerning this communication or earlier communications from the examiner should be directed to Rita J. Desai whose telephone number is 571-272-0684. The examiner can normally be reached on Monday - Friday, flex time..

If attempts to reach the examiner by telephone are unsuccessful, the examiner's supervisor, Thomas McKenzie can be reached on 571-272-0670. The fax phone number for the organization where this application or proceeding is assigned is 571-273-8300.

Information regarding the status of an application may be obtained from the Patent Application Information Retrieval (PAIR) system. Status information for published applications may be obtained from either Private PAIR or Public PAIR. Status information for unpublished applications is available through Private PAIR only. For more information about the PAIR system, see http://pair-direct.uspto.gov. Should you have questions on access to the Private PAIR system, contact the Electronic Business Center (EBC) at 866-217-9197 (toll-free). If you would like assistance from a USPTO Customer Service Representative or access to the automated information system, call 800-786-9199 (IN USA OR CANADA) or 571-272-1000.

Rita J. Desai
Primary Examiner
Art Unit 1625

R.D.
December 18, 2006